	<b>Center For Domestic Preparedness</b>
	Training Course Application
(FOR CDP USE ONLY)	(Please Print Legibly and Accurately)

(FOR CDP USE ONLY)	(Please Print Legibly and Accurately)	(Prerequisite certificate required)					
			WMD HAZMAT Technician (HT) ث				
Name:	Male		WMD Incident Command (IC)				
Name:(First) (MI)	(Last) Female	÷ 🗌	WMD Law Enforcement ف				
Social Security Number:	Date of Birth:		Protective Measures (LEPM TtT)				
Social Security Number: (For Student Record Use	e Only) (Month) (Day) (Y	Year)	Instructor Training Cartification				
Home Address: (No post office box/For FEDEX)	Organization/Work Address: (No post office box/	/For FEDEX)	ن Instructor Training Certification (ITC) (Prerequisite certificate required)				
(Street address)	(Organization Name)	-	Emergency Medical Services(EMS)				
		-	Emergency Responder Hazmat Technician Training (ER HM)				
(City, State, Zip)	(Street Address)						
		-	Check both boxes for IC/HOT or LEPM/HOT Combination courses				
(Home telephone or cell number)	(City, State, Zip)		Dates Requested: (Please enter three)				
(Fax number)	(Work Phone Number and ext)		1 <sup>st</sup>				
Email			2 <sup>nd</sup>				
Profession: Position/Title:			3 <sup>rd</sup>				
Airport of Departure:	Or if driving, Check Here	<u> </u>					
Area of Jurisdiction City □ Township □ County □ Metro □ District □ State □ Federal □ National □ Port □ Tribal Territory □	ship □   Discipline: Fire Suppression □ EMS □ Emergency Mgmt □ HAZMAT □						
Other (Please specify)	Other (Please specify)						

ن WMD Technical Emergency Response Training (TERT)

WMD Hands-On Training (HOT)

NOTICE: The Privacy Act, 5 U.S.C. 522a, requires that federal agencies inform individuals whether the disclosure is mandatory or voluntary. Your Social Security Account Number (SSN) will be used to identify you precisely when it is necessary. Although disclosure of your SSN is not mandatory, your failure to do so may impede selection for training at the Center for Domestic Preparedness.

## **Center for Domestic Preparedness**

## **Medical Screening Form**

(Please Print Legibly and Accurately)

Date Completed

			D	ate complete		
Responders Name:			Signature:			
Supervisors Name:		Signature:	Signature:			
(Verifying Official)  Course Requested:						
*	n Training C nust complet	ourse (HT), Wite this medical			_	
Heart Disease or Condition	Yes	No	Seizures or Epilepsy	Yes	No	
Chest Pain	Yes	No	Diabetes	Yes	No	
Frequent Fainting	Yes	No	Heat Injury (last 12 months)	Yes	No	
Asthma	Yes	No	Hyperventilated while wearing PPE	Yes	No	
Emphysema	Yes	No	Claustrophobia	Yes	No	
Chronic Bronchitis	Yes	No	Taking narcotic medication	Yes	No	
Other Lung or Chest Problems	Yes	No	Have an open wound or sutures	Yes	No	
Perforated Eardrum	Yes	No	•			

- 3. Any question with a <u>YES</u> answer requires the responder to have medical screening by a licensed physician certifying the responder is in appropriate health to perform tasks in personal protective clothing and respirator systems. High blood pressure (150 over 90) may preclude participation in Toxic Agent Training. **Pregnancy disqualifies responder candidates from attending this training.**
- 4. Forward Medical Screening Form and Physician Certification (if required) with Training Course Application. Additional medical screening will be conducted prior to entering the Toxic Agent Training Facility